U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 13 November 2006

In the Matter of:

L.O.C.,
Claimant,

CASE NO: 2005-BLA-5165

v.

T & H COAL COMPANY, INC.
Employer,

and

OLD REPUBLIC INSURANCE COMPANY,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGARMS,
Party-in-Interest.

Appearances:

Joseph E. Wolfe, Esq.
For the Claimant

Lucy G. Bowman, Esq.
For the Employer/Carrier

Before: LARRY W. PRICE
Administrative Law Judge

DECISION AND ORDER – DENYING REQUEST FOR MODIFICATION

This matter arises from a claim for benefits under the Black Lung Benefits Act, Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. 901 *et seq.* (Act), and applicable Federal Regulation, mainly 20 C.F.R. Parts 412, 718, and 725 (Regulations).

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to coal workers' pneumoconiosis or to the survivors of persons whose death was caused by coal workers' pneumoconiosis. Coal worker's pneumoconiosis is defined in the Act as "a chronic dust disease of the lung and its sequelae, including pulmonary and respiratory impairments, arising out of coal mine employment." 30 U.S.C. 902(b).

On November 3, 2004, this case was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held in Prestonsburg, Kentucky on January 10, 2006. At the trial I admitted Director's exhibits 1 through 42; Employer's exhibits 1 through 10 and Claimant's exhibits 1 through 4. The Court granted Claimant leave to submit CX 5 (as rehabilitation evidence) at the hearing and by Order dated June 30, 2006, but none was submitted. Employer submitted additional post hearing evidence, and I now admit Employer's exhibits 11 through 15. [1]

ISSUES

The following issues remain for resolution:

1. Timeliness: whether the claim was timely filed within 3 years of disability
2. Miner: whether Claimant was a miner as defined by the Act
3. Length of employment: the number of years Claimant worked in coal mines
4. Pneumoconiosis: whether the miner has pneumoconiosis as defined by the Act
5. Causal Relationship: whether the disease arose out of coal mine employment
6. Total disability: whether miner was totally disabled
7. Causation: whether miner's disability was due to pneumoconiosis
8. Responsible Operator: whether the named employer is the responsible operator
9. Insurance: whether the named employer secured the payment of benefits
10. Modification: whether there is a material change in conditions or a mistake in fact as required by 20 C.F.R. § 725.310

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

Claimant was born on July 7, 1944 and currently lives in Floyd County, Kentucky. (DX 3 at 1, Tr. 17). He was divorced from his wife in 1982. They had no children who were under eighteen or dependent upon them at the time this claim was filed. (DX 3.01- 3.02). Claimant has a 6th grade education. (DX 3-1).

Claimant experiences dyspnea especially while walking, lifting, carrying or ascending stairs. (DX 10, EX 3, 5). He wheezes at night and when he gets out of breath from exertion.

[1] The following abbreviations have been used in this decision: DX – Director's Exhibit; EX – Employer's Exhibit; CX – Claimant's Exhibit; TR – Transcript of the January 10, 2006 hearing; BCR – Board certified radiologist; and B – B-Reader.

(EX 5). He has two pillow orthopnea and a history of heart trouble. (DX 10, EX 3, 5). He was hospitalized after heart attacks in 2002 and 2003. He was also hospitalized in 1996 for bladder cancer and pneumonia, and 2001 for a stroke. He had an angioplasty done in 1989, and had bladder surgery in 1996. (DX-10).

The record contains varied statements regarding the Claimant's smoking history. Claimant testified that he smoked for approximately 35 years. Later in the testimony he reported smoking for 46 years. He also testified that he had quit smoking for one to three months prior to the hearing (Tr. 27, 41). Dr. Forehand stated that Claimant smoked three packs per day for 45 years (DX 10). Dr. Fino noted a smoking history of one and one half packs a day for 48 years (EX 3). Dr. Castle's report indicated that Claimant smoked up to 3 packs a day for 48 years. I find that Claimant has in excess of a 50 pack year smoking history.

Claimant originally filed for Federal Black Lung Benefits on March 21, 1989 (DX 1 at 547). The District Director denied the claim on July 25, 1989 and, following review of additional evidence, again denied benefits on September 20, 1989. (DX at 490, 508). Claimant filed a duplicate application for benefits on September 12, 1994. (DX 1 at 485). That claim was ultimately denied in a Decision and Order by Judge John M. Vittone on June 27, 1997. (DX 1 at 72). Claimant filed a third application for benefits on October 29, 1998. (DX 1 at 67). On February 9, 1999 the District Director denied the claim. (DX1 at 11).

Claimant filed a fourth application on November 4, 1999. (DX 1 at 3). Since this claim was filed within a year of the previous claim, the District Director gave the Claimant five days to identify whether the claim was intended to be a modification or a subsequent claim. Claimant failed to respond. Claimant filed the current application on November 21, 2003. (DX 3 at 1). District Director issued a Proposed Decision and Order on August 23, 2004, awarding benefits. (DX 32). Employer requested reconsideration, and then a formal hearing (DX 34). On November 3, 2004, the case was transferred to the Office of Administrative Law Judges. (DX 39).

In pertinent part the regulations provide that any party may request a modification on the grounds of a change in conditions or a mistake in a determination of fact, so long as such a request is within one year of a denial of a claim or the last payment of benefits. §725.310(a). Claimant filed an application for benefits on November 4, 1999, which is within one year from the denial of the Claimant's previous claim on February 9, 1999, and therefore this application qualifies as a modification. Nothing in the file suggests that the District Director took any action on the 1999 application. According to the Regulations, the earlier application is still pending because it was never finally denied. 20 C.F.R. § 725.309(b). Claimant filed the current application on November 21, 2003. In the case of a claimant who files more than one claim for benefits, the later claim shall be merged with the earlier claim for all purposes if the earlier claim is still pending. 20 C.F.R. Part 725.309 (d). The regulations mandate the merger of the 2003 claim with the pending 1999 claim, which in turn means that this claim is a modification of the Proposed Decision and Order denying benefits issued by the District Director on February 9, 1999.[2] Revised §725.309 and §725.310 do not apply to those claims filed before, nor pending as

[2] The Proposed Decision and Order became final sixty days after the issuance of the Proposed Decision and Order because Claimant failed to submit additional evidence or request a hearing. (DX 1 at 11).

of January 19, 2001. 20 C.F.R. 725.2. Therefore this case will be analyzed under the regulations that were in place prior to the 2001 revisions.

Claimant's Testimony

Claimant testified to working sporadically for several mines, including F. Taylor Mining Company, Bid Mack Mining, some smaller mines and T & H coal company, between 1969 and 1990. (Tr. 18 – 23, 34). He reported working numerous jobs during his coal mining employment, including hand loading, drilling, foreman, roof bolter, and cutting machine operator. (Tr. 19 – 23). Claimant reported that his last coal mining job was a cutting machine operator for T & H Coal Company. This job entailed maneuvering the cutting machine to cut the coal ten feet across at the bottom of the mine. Claimant testified that he encountered a great amount of dust at this job; "I've sat on the cutting machine and it was so dusty I've spit gobs of dust out of my mouth and nose… every day." (Tr. 25).

Timeliness

Under § 725.308(a), a claim of a living miner is considered timely if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. Because the record contains no evidence that Claimant received the requisite notice more than three years prior to filing of his initial claim or any subsequent claim for benefits, I find that his claim was timely filed.

Status as a Miner under the Act

Miners who establish the applicable elements of entitlement may receive benefits under the Act. 30 U.S.C. § 901(a); 20 C.F.R. § 718.1(a). A "miner" is defined as "any person who works or has worked in or around a coal mine or coal preparation facility in the extraction, preparation, or transportation of coal..." 20 C.F.R. § 725.202(a). The Sixth Circuit Court of Appeals has adopted the two-prong, function-situs test. Director, OWP v. Consolidated Coal Co., [Petracca], 884 F.2d 485 (6th Cir. 1988). The "situs prong" of the test requires that claimant's work occurred in or around a coal mine or coal preparation facility. Whisman v. Director, OWCP, 8 BLR 1-96 (1985); Slone v. Director, OWCP, 12 BLR 1-92 (1988). The "function prong" requires that the work be integral to the extraction or preparation of coal and not merely ancillary to the delivery and commercial use of processed coal. Falcon Coal Co., Inc. v. Clemons, 873 F.2d 916, 12 BLR 2-271 (6th Cir. 1989).

As part of the situs prong, it is the function of the land, not the individual, that is determinative of whether the situs of the work was in or around a coal mine. Therefore, I must determine whether the intended use of the area of land on which Claimant was employed was for the extraction or preparation of coal. McKee v. Director, OWCP, 2 BLR 1-804 (1980). The record establishes that T & H Coal Co. operates a coal mine for the purpose of extraction of coal. Therefore the situs prong of this test is fulfilled.

The next part of the analysis, the function prong, requires that the individual's work contribute to the extraction and preparation of coal. The record shows that Claimant had worked numerous jobs during his coal mining employment, including hand loading, drilling, foreman, roof bolter, and cutting machine operator. Claimant reported that his last coal mining job was a cutting machine operator for T & H Coal Company. This job entailed maneuvering the cutting machine to cut the coal at the bottom of the mine for the purpose of extraction. I therefore find that the function prong is filled and Claimant is a "miner" under the definition provided by the Regulations.

Responsible Operator

In order to be deemed the responsible operator liable for the payment of benefits, an employer must have been the last employer in the coal mining industry for which the miner had his most recent period of coal mine employment of at least one year, including one day after December 31, 1969. 20 C.F.R. §§ 725.492(a), 493(a) (2004). In this case, Claimant testified that he had last worked for T & H Coal Co. for approximately six months in 1990. This contention is supported by the Social Security records. Prior to this six month period, Claimant had done some work with T & H Coal in 1987, and worked the entire year in 1986. There is no evidence that Claimant worked in any other coal mine between 1986 and 1990. (EX 7 at 6). Therefore, I find that T & H Coal Co. is properly named as the responsible operator in this claim.

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. Claimant bears the burden of proof in establishing the length of his coal mine work. Shelesky v. Director, OWCP, 7 BLR 1-34, 1-36 (1984); Rennie v. U.S. Steel Corp., 1 BLR 1-859, 1-862 (1978). On his application for benefits, Claimant alleged fifteen years of coal mine employment. The evidence in the record includes a Social Security Statement of Earnings encompassing the years 1962 to 1993, applications for benefits, employment history forms, a letter from Employer, and Claimant's testimony. (DX 7; DX 3; DX 4; DX 6; Tr. 19 - 26).

The Act fails to provide specific guidelines for computing the length of a miner's coal mine work. However, the Benefits Review Board consistently has held that a reasonable method of computation, supported by substantial evidence, is sufficient to sustain a finding concerning the length of coal mine employment. Croucher v. Director, OWCP, 20 BLR 1-67, 1-72 (1996) (en banc); Dawson v. Old Ben Coal Co., 11 BLR 1-58, 1-60 (1988); Niccoli v. Director, OWCP, 6 BLR 1-910, 1-912 (1984). Thus, a finding concerning the length of coal mine employment may be based on many different factors, and one particular type of evidence need not be credited over another type of evidence. Calfee v. Director, OWCP, 8 BLR 1-7, 1-9 (1985).

Upon review of the record in this case, it is initially noted that the District Director found 11 years of coal mine employment, starting on January 1, 1971 and ending June 30, 1990. (DX 32 at 4). Claimant testified that he started working in the coal mines in 1969 and worked steady from 1975 through 1987. (Tr. 18, 23). He reported working for F. Taylor Mining Company from 1969 through 1972, then with Bid Mack Mining in 1971, and began working for Employer in 1975. (Tr. 18 – 23). In a letter returned to the Claim's examiner, Employer reported that Claimant worked from 1969 through 1970, 1978 through 1979, 1980 through 1984, 1985 through 1987, and for six months in 1990. Employer also stated that Claimant did some work between 1970 and 1978, but these records were destroyed due to water damage. (DX 6-1).

Based upon my review of the record, I place the greatest weight on the Social Security records because they are documented, independent evidence of Claimant's coal mine employment. The Social Security records show that Claimant worked in coal mines from between 1969 to 1990. The Claimant's salary for the years 1976 through 1984, 1986 and 1990 ranged from $10,492.05 to $26,312.69, which indicates that Claimant should be credited with a full year of work for each of those eleven years. Claimant's salary during 1969, 1975, 1985 and 1987 indicates that Claimant only worked a fraction of the time during these years. The salary during these years ranged from $1140.92 to $5451.31. The combination of earnings from these fractional years constitutes an additional year of coal mine employment. In sum, Claimant has worked a total of 12 years of qualifying coal mine employment.

Ability to Pay

The regulations at 20 C.F.R. §725.492(a)(4) (2000) provide that the operator or employer must be capable of assuming its liability for the payment of continuing benefits pursuant to the methods enumerated therein. The methods listed for an operator to provide payment of benefits include obtaining a policy or contract of insurance, qualifying as a self-insurer, or possessing assets available for the payment of benefits. 20 C.F.R. §§725.492(a)(4)(i)-(iii) and 725.494 (2000). Here, the Employer does have insurance coverage and there is no evidence showing an inability of either Employer or Employer's carrier to pay benefits. I find that the T & H Coal Company is capable of assuming its liability for the payment of benefits if awarded.

NEW MEDICAL EVIDENCE

Section 725.310 provides that a claimant may file a petition for modification within one year of the last denial of benefits. Modification petitions may be based upon a change in condition or a mistake in a determination of fact. 20 C.F.R. 725.310(a).
In deciding whether the claimant has established a change in conditions, I must "perform an independent assessment of the newly submitted evidence, in conjunction with evidence previously submitted, to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement…." Napier v. Director, OWCP, 17 BLR 1-111, 1-113 (1993); Nataloni v. Director, OWCP, 17 BLR 1-82, 1-84 (1993). In deciding whether the prior decision contains a mistake in a determination of fact, I must review all the evidence of

record, including evidence submitted since the most recent denial. Nataloni, 17 BLR at 1-84; Kovac v. BCNR Mining Corp., 14 BLR 1-156, 1-158 (1990), aff'd on recon. 16 BLR 1-71, 1-73 (1992).

The following is a summary of the medical evidence submitted with the instant request for modification. While this decision is based on a de novo review and consideration of the administrative record as a whole, not all of the evidence that has been introduced prior to the instant request for modification may again be listed except as required for an analysis of the current request for modification.

X-ray Reports

Exhibit	Doctor	Qualifications	Date of X-ray	Date of Reading	Film Quality	Interpretation
DX-10	Forehand	B	12/30/03	12/30/03	1	1/1, s/t, 4z
CX-1	Alexander	B/BCR	12/30/03	08/09/04	1	½, p/s, 6z, A-?
EX-1	Wiot	B/BCR	12/30/0 3	11/22/04	2, mottle	Neg CWP, pa
EX-3	Fino	B	06/10/04	07/02/04	1	Negative
EX-5	Castle	B	12/15/04	12/23/04	1	1/1, t/s, 4z, cg
EX-6	Wiot	B/BCR	12/15/04	02/24/05	2, over-exposed (dark)	Neg CWP., cg
CX-3	DePonte	B/BCR	12/15/04	07/05/05	1	1/1, p/s, 6z, "A", ca
CX-2	DePonte	B/BCR	12/20/05	12/20/05	1	2/1, s,s, 6z, A, ca
EX-11	Wiot	B/BCR	12/20/05	05/06/06	1	Neg. CWP, pa, OD,

Pulmonary Function Studies[3]

Exhibit #	Physician	Date of Study	Tracings Present?	Flow-Volume Loop?	Broncho-dilator?	FEV1	FVC/ MVV	Age/ Height	Qualify?	Coop and Comp. Noted
DX-10	Forehand	12/30/03	Yes	Yes	No	2.63	3.68/ na	59/ 68	No	Good
EX-3	Fino	06/10/04	Yes	Yes	Yes	1.96/ 1.98	2.89/ 2.96	59/ 69	No	Not good effort

[3] 20 C.F.R. 718 Appx. B establishes the standards for the administration and interpretation of pulmonary function tests.

Exhibit #	Physician	Date of Study	Tracings Present?	Flow-Volume Loop?	Broncho-dilator?	FEV1	FVC/ MVV	Age/ Height	Qualify?	Coop and Comp. Noted
EX-5	Castle	12/15/04	Yes	Yes	Yes	1.86/ 1.83	2.82/ 2.69	60/ 69	No	poor effort

Arterial Blood Gas Studies[4]

Exhibit #	Physician	Date of Study	Altitude	Resting (R) Exercise (E)	PCO2	PO2	Qualify?	Age	Comments
DX-10	Forehand	12/29/03	0 to 2999	R	29.0	68.0	Yes	60	
				E	24.0	58.0	Yes		
EX-5	Castle	06/10/04	0 to 2999	R	34.8	66.2	No	60	Mild Hypoxemia; carboxy hemoglobin level is elevated
EX-3	Fino	12/15/04	0 to 2999	R	31.3	73.4	No	59	

Narrative Medical Evidence

Physician Opinions

Claimant chose Dr. J. Randolph Forehand, a B-reader, to conduct the pulmonary evaluation required under § 725.406.[5] The evaluation was comprised of a physical examination, a medical and work history, a chest X-ray, and pulmonary function and arterial blood gas tests. Dr. Forehand issued his initial report to the District Director, on December 30, 2003 (DX 10). His report reflects that his conclusions are based on a coal mine employment history of 15 years and a smoking history of 3 packs per day for 40 years with a decline to three cigarettes a day prior to the exam. (DX 10 at 2). Dr. Forehand was aware that the Claimant had been hospitalized for pneumonia and bladder cancer in 1996, for a stroke in 2001, and for heart attacks in 2002 and 2003. Dr. Forehand was also informed that Claimant had an angioplasty in 1989 and bladder surgery in 1996. (DX 10 at 3).

In his report, Dr. Forehand found a normal configuration upon inspection of the lungs. He noted "crackles heard at bases" on auscultation of the lungs. He also reported that there was no tenderness regarding palpation and no dullness in regards to percussion. (10 at 4). Dr. Forehand found no acute changes from Claimant's electrocardiogram. (DX 10 at 4). Dr. Forehand's report reflects that the Claimant told him the following: he has daily yellow phlegm;

[4] 20 C.F.R. 718 Appx. C establishes the standards for the administration and interpretation of arterial blood gas studies.

[5] Dr. Forehand was identified as a B-reader in the NIOSH Comprehensive Reader List found at: http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3EF_08_05.HTM

wheezes nightly; sleeps with two pillows; dyspnea for six years, especially while bending, lifting and walking; and angina for which Claimant is taking nitroglycerin. (DX 10 at 3).

Dr. Forehand summarized numerous diagnostic tests. He found that the chest x-ray showed coal workers' pneumoconiosis. The pulmonary function test revealed a normal ventilatory pattern and the arterial blood gas study showed arterial hypoxemia. (DX 10 at 4). Dr. Forehand diagnosed coal workers' pneumoconiosis based upon Claimant's history, physical examination, x-ray and the arterial blood gas study. He attributed this diagnosis to coal mine dust exposure. (DX 10 at 5). Dr. Forehand reports "a significant respiratory impairment is present; insufficient residual oxygen transfer capacity remains to return to last coal mining job. Unable to work. Totally and permanently disabled. The coal workers' pneumoconiosis is the sole factor contributing to respiratory impairment." (DX 10 at 5).

Employer presented a medical report from Dr. Gregory J. Fino, who examined Claimant on June 10, 2004. (EX 3 at 1). Employer also presented a supplemental report dated December 20, 2005. (EX 9). Dr. Fino is a B-reader and board-certified in internal medicine with a subspecialty in pulmonary disease. (EX 4 at 4). His report was based upon a chest x-ray that he performed in conjunction with the examination, a review of numerous other radiographic studies that included x-rays and a CT scan, Claimant's medical and work history, and numerous diagnostic tests. (EX 3). His conclusions are based on a coal mine employment history of 17 years with heavy labor in his last job and a smoking history of one and one half packs of cigarettes daily since 1958 and a decrease to three cigarettes per day for the month prior to the examination. (EX 3 at 2). Dr. Fino was aware that the Claimant had suffered from bladder cancer, pneumonia, one stroke, one heart attack and heart disease. He also knew that Claimant had right carotid artery surgery. (EX 3 at 3).

Based upon the physical examination, Dr. Fino reported that the lungs were "clear to auscultation and percussion on a tidal volume breath and a forced expiratory maneuver without wheezes, rales, rhonci, or rubs." (EX 3 at 4). Dr. Fino noted that Claimant complained of shortness of breath for twelve years, dyspnea when walking or ascending stairs, walking uphill, lifting, carrying or performing manual labor and chest pain. There is no complaint of cough, mucus, wheezing, orthopnea or paroxysmal nocturnal dyspnea. (EX 3 at 2).

Dr. Fino summarized numerous diagnostic tests. He interpreted the x-ray from the evaluation as negative for pneumoconiosis. (EX 3 at 4). He also found the Spirometry invalid "because of a premature termination to exhalation and a lack of reproducibility in the expiratory tracings". (EX 3 at 5). Based on the tests of lung capacity, Dr. Fino found the FRC, RV and the RV/TLC ratio to be elevated, which is consistent with obstruction. (EX 3 at 5). The Carboxyhemoglobin levels were also elevated. Dr. Fino found the arterial blood gas studies to be normal, and the measurement of diffusing capacity to be invalid. (EX at 5-6).[6]

[6] Dr. Fino explained that he had not conducted an exercise study because it was "not helpful, and Claimant has significant history of coronary artery disease". (EX at 11).

In his report, Dr. Fino stated that the Claimant's pulmonary examination was normal, and that Claimant had atherosclerotic coronary vascular disease. (EX 3 at 11). He concluded that there was no evidence of radiographic pneumoconiosis, no ventilatory impairment when Claimant gives good effort, and no evidence of respiratory impairment or pulmonary disability. (EX 3 at 11-12). Dr. Fino "believed that Claimant had continued to smoke, but that it hadn't caused a problem." Dr. Fino found Claimant to be disabled due to coronary artery disease, which is not related to coal dust exposure. He doesn't think there is any chronic hypoxemia or impairment in oxygen transfer. Dr. Fino did not believe there has been any significant change in his condition since 1998. (EX 3 at 12).

In a supplemental report, Dr. Fino confirmed his prior conclusion after reviewing new evidence consisting of hospital and medical records from between May 15, 2004 through January 10, 2005 and Dr. DePonte's interpretation of the x-ray dated December 15, 2004. (EX 9 at 1). He explained that the opacity in the x-ray dated December 15, 2004 was most likely a carcinoma because this opacity did not show up on any of the previous x-rays or the CT scan taken five months prior. Based on this information, Dr. Fino concluded that this opacity was not complicated pneumoconiosis. Dr. Fino also identified the opacity in the lower portion of the right lung in the December 15, 2004 x-ray as "a small pleural effusion noted on the right side and a pneumonia noted on the right side from previous chest x-rays and Ct scans". (EX 9 at 5).

Employer presented a medical report and supplemental report from Dr. James R. Castle, who examined Claimant on March 9, 2005. (EX 5, EX 10). Dr. Castle is a B-reader and is board certified in internal medicine and pulmonary disease. (EX 7 at 3). His report was based upon a chest x-ray that he performed in conjunction with the examination, a review of numerous other radiographic studies that included x-rays and a CT scan, Claimant's medical and work history, and numerous diagnostic tests. (EX 5 at 2-4). His report reflects that his conclusions are based on a coal mine employment history of 17 years culminating in a dusty and labor intensive position and a smoking history of three packs per day since the age of 14 and only five cigarettes a day for the three to four months preceding the examination. (EX 5 at 1-2). Dr. Castle was aware that the Claimant had suffered heart trouble, had a heart attack in August of 2002, was hospitalized a week before the examination for chest pain, and had underwent cardiac catheterization and had a balloon angioplasty with a stent placed. (EX 5 at 1).

Based upon the Claimant's chest exam, Dr. Castle reported that Claimant had a "normal AP diameter", no "intercostals retractions and did not use the accessory muscles with quiet breathing". (EX 5 at 2 at 3). He also stated that Claimant "had normal percussion and normal tactile fremitus. He had equal breath sounds throughout, although they were slightly diminished." (EX 5 at 3). Dr. Castle did not hear any "rales, rhonchi, wheezes, rubs, crackles or crepitations" (EX 5 at 3). Dr. Castle noted that Claimant complained of shortness of breath since approximately 1996 and claimed that it prevented him from walking more than one block on level ground at his own speed or from climbing one flight of stairs without stopping. Dr. Castle stated that Claimant does not have a cough or sputum production, although he does have wheezing at night and when he gets out of breath. (EX at 1).

Dr. Castle summarized the diagnostic tests conducted at the time of the Claimant's examination. Dr. Castle found the x-ray to show "t/s type opacities in both mid and lower lung zones with a profusion of 1/1. There was also evidence of an infiltrate/ scar in the right lower lung zone, probably inflammatory." (EX 5 at 3). He expressed the need to compare this film with older x-rays, and also stated that he had found old Granulomatous disease. He concluded that the changes in the x-ray were not pneumoconiosis and instead were inflammatory in nature. (EX 5 at 3). Dr. Castle had performed pulmonary function studies on the Claimant. He found the spirometry to be valid, which showed "evidence of a mild reduction in the forced vital capacity with a moderate reduction in the FEV1." (EX 5 at 3). He reported that the total lung capacity was normal, but that the study showed evidence of moderate airway obstruction consistent with emphysema. (EX 5 at 3). He noted that the arterial blood gas studies showed evidence of very mild hypoxemia.[7] (EX 5 at 3). The carboxyhemoglobin level was significantly elevated. An electrocardiogram was also performed and yielded abnormal results. (EX 5 at 4).

Based upon the data obtained at the time of Claimant's evaluation and an extensive review of all the additional medical data, Dr. Castle found that Claimant did not suffer from coal workers' pneumoconiosis. (EX 5 at 18). Dr. Castle explained that smoking and coal dust exposure were both risk factors for pulmonary disease, but only if the Claimant was a "susceptible host". Also Dr. Castle stated that coronary artery disease is another risk factor for the development of pulmonary symptoms. (EX 5 at 19). However, despite all the risk factors, Dr. Castle found that Claimant "did not demonstrate any physical findings indicating the presence of an interstitial pulmonary process. He did not have a consistent finding of rales, crackles, or crepitations." (EX 5 at 19).

Dr. Castle opined that there was no radiographic evidence of pneumoconiosis. According to Dr. Castle, the x-ray taken at the time of Claimant's evaluation showed "irregular opacities" which he classified as 1/1. However, he explained that these opacities were not consistent with coal worker's pneumoconiosis, but rather were indicative of "an inflammatory process such as pneumonia." (EX 5 at 19). Dr. Castle reported that the review of past radiographic evidence, including a CT scan, supported his finding that Claimant did not suffer from pneumoconiosis.

The physiologic studies showed "evidence of moderate airway obstruction associated with gas trapping and a reduction in diffusing capacity." (EX 5 at 19). Dr. Castle noted that the studies obtained by Dr. Forehand on December 30, 2003 show normal spirometry, where as the studies obtained by Dr. Fino six months later show "a significant reduction in the forced vital capacity and FEV1." In Dr. Castle's opinion, these changes were caused by pulmonary emphysema brought on by tobacco smoking. He also opined that the airway obstruction is caused entirely and solely by smoking because the changes have occurred long after Claimant left the coal mining industry and there is no finding of a disabling respiratory impairment. (EX 5 at 20). Dr. Castle also attributed the mild hypoxemia shown in the arterial blood gas studies to tobacco smoking.

[7] Dr. Castle explained that Claimant had not performed exercise testing because of his cardiac condition.

Dr. Castle concluded that Claimant was permanently and totally disabled as a result of pulmonary emphysema caused by tobacco smoke. He reported that Claimant was totally and permanently disabled by coronary heart disease unrelated to coal mine dust exposure and coal workers' pneumoconiosis. It was Dr. Castle's opinion that Claimant was not totally disabled by any process related to Claimant's coal mine employment. (EX 5 at 20). Dr. Castle stated that this conclusion was supported primarily by Claimant's failure to demonstrate physiologic changes indicative of pneumoconiosis. (EX at 20).

In a supplemental report, Dr. Castle reviewed new evidence consisting of hospital and medical records from between May 15, 2004 through January 10, 2005 and Dr. DePonte's interpretation of the x-ray dated December 15, 2004 and concluded that none of the new evidence alters any of his prior opinions. (EX 10 at 3, 5). Dr. Castle did address irregular type opacities in Claimant's lungs, but explained that they were not typical of those associated with coal worker's pneumoconiosis. He also cast doubt on Dr. DePonte's discovery of a large type A opacity because no other radiologists or B-readers had found that opacity.

Medical Records

I have reviewed the medical records from Dr. Roger Jurich and Highlands Regional Medical Center. (EX 8). According to the records, Dr. Jurich treated Claimant on several occasions between May of 2004 and December of 2005. (EX 8). These records document Claimant's hospitalizations and treatment for congestive heart failure, a cerebrovascular accident (CVA), and pneumonia. Claimant consulted Dr. Jurich for numerous symptoms over time including dyspnea, wheezing, cough, congestion, chest pain, and occasional production of white mucus. (EX 8).

On December 8, 2004 Claimant was seen for "COPD with exacerbation, emphysema, bronchitis, bronchiolitis, s/p coronary bypass surgery, angina pectoris, and failed stress test".[8] In May of 2005 Claimant was checked into the Medical Center with the diagnosis of CVA. (EX 14). On October 12, 2005 Claimant sought treatment at Highlands Regional Medical Center of Eastern Kentucky for chest pain. (EX 12). The discharge diagnoses included the following: angina, smoker bronchitis, status post cardiac stent placement times 2, chronic pulmonary disease, emphysema, bronchiolitis, pulmonary ischemia, hyperlipidemia, hypertriglyceridemia, chronic obstructive airway, and obstructive airway disease. (EX 12). The last record from Dr. Jurich is a progress note from December 30, 2005 in which Dr. Jurich performed a check up for the patient and reported that patient suffered from "COPD, smoker's bronchitis, emphysema, s/p CVA with left temporatl and left frontal lesions, dyslipidemia, chest pain with normal cardiac stress test Octovber 2005, chest pain from reflux esophagitis, anti coagulation, and bladder cancer.[9]

Throughout the records, Dr. Jurich noted Claimant's smoking history, but never reported any occupational history. Although Dr. Jurich diagnosed COPD, he did not list any etiology for that ailment. There is no mention of clinical pneumoconiosis in any of the records. (EX 8).

[8] COPD is the abbreviation for Chronic Obstructive Pulmonary Disease.

[9] Throughout Dr. Jurich's treatment of Claimant, Claimant was also seeing Dr. McDonald for treatment for bladder cancer. On September 7, 2005, Dr. McDonald removed a small bladder tumor. (EX 13).

Change in Condition

In considering the issue of modification, the Administrative Law Judge must conduct an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish the element or elements of entitlement which defeated the claim in the prior decision. Napier v. Director, Office of Workers' Compensation Programs, 17 B.L.R. 1-111, 1-113 (1993); Nataloni v. Director, Office of Workers' Compensation Programs, 17 B.L.R. 1-82, 1-84 (1993). If the newly submitted evidence is sufficient to establish modification under § 725.310, then the Administrative Law Judge must consider all of the evidence of record to determine whether the claimant has established entitlement to benefits on the merits of the claim. Kovac v. BCNR Mining Corp., 14 B.L.R. 1-156, 1-158 (1990), modified, 16 B.L.R. 1-71 (1992).

In this case, Claimant was unable to prove any necessary element in the prior denial of benefits. Therefore, if the new evidence establishes even a single element then I will review the record in its entirety to determine whether the Claimant is entitled to black lung benefits.

Newly Submitted Evidence: Pneumoconiosis and Causation

Because Claimant filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. To establish entitlement to benefits under this part of the regulations, a claimant must prove by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. 20 C.F.R. §725.202(d); Anderson v. Valley Camp of Utah, Inc., 12 BLR 1-111, 1-112 (1989). In Director, OWCP v. Greenwich Collieries, et al., the U.S. Supreme Court stated that where the evidence is equally probative, the claimant necessarily fails to satisfy his burden of proving the existence of pneumoconiosis by a preponderance of the evidence. 114 S. Ct. 2251 (1994).

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. In evaluating the x-ray evidence, I assign heightened weight to interpretations of physicians who qualify as either a board-certified radiologist or "B" reader. Dixon v. North Camp Coal Co., 8 BLR 1-344, 1-345 (1985). I assign greatest weight to interpretations of physicians with both of these qualifications. Woodward v. Director, OWCP, 991 F.2d 314, 316 n.4 (6th Cir. 1993); Sheckler v. Clinchfield Coal Co., 7 BLR 1-128, 1-131 (1984).

The evidence of record contains nine interpretations of four chest x-rays. Of these interpretations, four were negative for pneumoconiosis, five were positive, and two of the positive interpretations indicated the presence of a type "A" opacity consistent with complicated

coal workers' pneumoconiosis.[10] There were three interpretations of the X-ray dated December 30, 2003. Dr. Alexander, a board certified radiologist and B reader, interpreted the x-ray as positive for pneumoconiosis with a profusion of 1/2; whereas Dr. Wiot, a dually qualified radiologist, did not. Dr. Alexander also reported the possibility of complicated pneumoconiosis.[11] Dr. Forehand, a B reader, found pneumoconiosis with a profusion of 1/1. Dr. Wiot was the Chairman of the Workgroup of the ILO Classification System in 1987 through 1988 and participated in numerous conferences regarding ILO classifications and pneumoconiosis. I grant Dr. Wiot's opinion greater weight due to his superior qualifications. Here the most qualified specialist interpreted the x-ray as negative; however there is a consensus between the two lesser qualified specialists that the x-ray is positive. Accordingly, I am unable to determine whether the December 30, 2003 chest x-ray is positive or negative for pneumoconiosis.

The X-ray dated June 10, 2004, was interpreted by Dr. Fino, a B-reader, as negative for pneumoconiosis. This is the only interpretation of this x-ray, therefore the June 10, 2004 x-ray is negative for pneumoconiosis.

Dr. DePonte, a dually qualified radiologist, found the presence of pneumoconiosis in an x-ray dated December 15, 2004, whereas once again Dr. Wiot did not. Dr. DePonte also indicated that there was a type "A" opacity in the claimant's lung, indicating the existence of complicated pneumoconiosis. Dr. Castle, a B-reader interpreted the film as positive.[12] Once again, considering the superior qualifications of Dr. Wiot and the conflict between the two dually qualified specialists, Dr. Castle's assessment does not resolve the disparity between the assessments of two dually qualified specialists. As a result, I find the evidence in association with the December 15 2004 x-ray to be in equipoise.

As before, Dr. Deponte, a dually qualified radiologist, found evidence of both simple and complicated pneumoconiosis in the December 20, 2005 film. Dr. Wiot, a dually qualified radiologist, found no evidence of pneumoconiosis. Once again, I grant Dr. Wiot's opinion greater weight due to his superior qualifications. As a result, I find the evidence pertaining to the December 20, 2005 film to be negative.

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[10] In Cranor v. Peabody Coal Co., 22 B.L.R. 1-1 (1999) (en banc on reconsideration), the Board held that it was proper for the administrative law judge to consider a physician's x-ray interpretation 'as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment' in the text box of the x-ray report form. In particular, the interpreting physician's comment that the Category 1 opacities found on the chest x-ray was not coal workers' pneumoconiosis did not affect his diagnosis of the disease under §718.202(a)(1), 'but merely addresses the source of the diagnosed pneumoconiosis.'

[11] Dr. Alexander merely indicated that complicated pneumoconiosis was a possibility by placing a question mark next to the selection for a type A opacity. (CX 1)

[12] Even though Dr. Castle marked the appropriate box indicating a presence of pneumoconiosis, he stated in the comment section that he did not think these changes were due to pneumoconiosis, rather he attributes these nodules to granuloma or scarring. However, he did not check the appropriate box to signify that the X-ray is negative for pneumoconiosis and he did select a classification that is associated with a positive reading for pneumoconiosis. (EX 5). Therefore the X-ray will be considered positive despite commentary to the contrary. See footnote 10.

In summary, two of the four x-ray were negative for pneumoconiosis and evidence from the remaining two x-rays was in equipoise. Since the preponderance of the radiographic evidence is negative for pneumoconiosis, Claimant is unable to establish the presence of pneumoconiosis through radiographic evidence under 20 C.F.R. §718.202(a)(1).

Under § 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. This section is inapplicable to this claim because the record contains no such evidence.

Under § 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at §§ 718.304 to 718.306 applies. The presumptions at §§ 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Complicated pneumoconiosis is diagnosed after a finding of an opacity greater than one centimeter is categorized as a type A, B or C. In this case, there is conflicting evidence pertaining to the existence of complicated pneumoconiosis in Claimant's lungs.

Dr. Alexander, a dually qualified radiologist, reported the possibility of a type A opacity in Claimant's lungs based upon the December 30, 2003 x-ray. Dr. Alexander had placed a check on the ILO indicating the presence of a type A opacity, but he placed a question mark next to this check. Dr. Wiot, another dually qualified radiologist, interpreted the same x-ray and failed to find any evidence of pneumoconiosis or complicated pneumoconiosis. Dr. Forehand, a B-reader, did agree with Dr. Alexander's positive reading; however Dr. Forehand did not find any evidence of complicated pneumoconiosis. Considering the failure of the specialists to agree, Dr. Wiot's superior qualifications and Dr. Alexander's uncertainty pertaining to this diagnosis, I find this x-ray to be negative for complicated pneumoconiosis.

The June 10, 2004 x-ray presents no evidence of complicated pneumoconiosis.

Dr. DePonte, a dually qualified radiologist, found complicated pneumoconiosis in the December 15, 2004 x-ray. Dr. Castle, found pneumoconiosis but no evidence of complicated pneumoconiosis. Dr. Wiot found no evidence of either simple or complicated pneumoconiosis. Dr. DePonte's assessment is outweighed by the consensus between Dr. Castle and Dr. Wiot that this x-ray does not support a finding of complicated pneumoconiosis. Therefore, I find the December 15, 2004 x-ray to be negative for complicated pneumoconiosis.

Dr. DePonte once again diagnosed complicated pneumoconiosis based upon the December 20, 2005 x-ray. Dr. Wiot interpreted this x-ray as negative for both simple and complicated pneumoconiosis. Dr. Wiot's opinion is entitled to greater weight given his superior credentials; therefore I find the December 20, 2005 x-ray to be negative for complicated pneumoconiosis.

In summary, a diagnosis of complicated pneumoconiosis is not supported by any of the newly submitted x-rays. Dr. DePonte is the only specialist to present a concrete diagnosis of complicated pneumoconiosis. Dr. Alexander was unsure and Dr. Wiot found such a diagnosis to be unsupported. Not one of the less qualified B- readers found complicated pneumoconiosis, despite findings of simple pneumoconiosis. I find that the radiographic evidence does not support a finding of complicated pneumoconiosis under § 718.304.

The final method by which Claimant can establish that he suffers from the disease is by well- reasoned, well-documented medical reports as per §718.202(a)(4). A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. Hoffman v. B&G Construction Co., 8 B.L.R. 1-65 (1985); Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295 (1984). A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. Fields, supra. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. Wilburn v. Director, OWCP, 11 B.L.R. 1-135 (1988).

I find that the Claimant has failed to establish pneumoconiosis on the basis of medical opinion evidence. The sole medical opinion in support of such a finding was rendered by Dr. Forehand. Claimant chose Dr. Forehand to complete his Department of Labor medical evaluation. Dr. Forehand marked that Claimant suffered from an occupational lung disease caused by coal mine employment based on his chest x-ray findings, the arterial blood gas study, Claimant's history and the physical examination. Dr. Forehand bases his conclusion in part upon his positive interpretation of the x-ray taken in conjunction with Claimant's evaluation. I have determined this x-ray to be in equipoise; therefore it does not contribute any support to Dr. Forehand's diagnosis of pneumoconiosis.[13]

Dr. Forehand considered an accurate account of Claimant's smoking and coal mine employment history. However, his diagnosis of pneumoconiosis does not account for the role, if any, that Claimant's smoking history had on the symptoms Claimant demonstrated at the examination. Dr. Forehand's failure to address the role of Claimant's smoking history undermines his finding of pneumoconiosis. In order to diagnose clinical or legal pneumoconiosis "arising out of coal mine employment" as required by § 718.201(a)(1-2), the "disease" must be significantly related to, or substantially aggravated by dust exposure in coal mine employment. § 718.201(b). The failure to address the role of Claimant's smoking history

[13] Dr. Forehand identified the clinical findings and objective data upon which he based his opinion. However, he only identified the basic categories of evidence upon which he relied. Dr. Forehand did not identify and explain how specific clinical findings and observations supported his conclusion. For instance, Dr. Forehand detected crackles at the bases of the lungs, but he did not specifically identify this finding as one upon which he relied to support his conclusion.

means that Dr. Forehand did not resolve the question of whether the occupational disease he diagnosed was significantly contributed to or substantially aggravated by dust exposure in coal mine employment. I find that Dr. Forehand's diagnosis of pneumoconiosis does not amount to a reasoned medical opinion.

In the alternative, I accord greater weight to the opinions by Dr. Fino and Dr. Castle that Claimant does not have pneumoconiosis, on the basis of their overall documentation, review of Claimant's medical history and diagnostic tests. Dr. Fino addressed the potential effects of both coal mine dust and tobacco smoking. He reported no pulmonary disability or respiratory impairment. Dr. Fino based this opinion in part on the June 10, 2004 x-ray, which is in agreement with this court's finding that the x-ray is negative. Unlike Dr. Forehand, Dr. Fino reviewed an extensive number of medical records and reports.[14] Dr. Fino identified an opacity found in the December 15, 2004 x-ray as a carcinoma rather than pneumoconiosis. He explained that it was unlikely to be a sign of pneumoconiosis because it wasn't found in a CT scan or x-rays taken five months prior, but he does not provide an explanation as to why this fact would rule out pneumoconiosis. Although Dr. Fino could have been more specific regarding his finding that Claimant had no respiratory impairment, his conclusion is supported by Dr. Castle.

Dr. Castle also found no evidence of pneumoconiosis. Dr. Castle's evaluation of the Claimant included an x-ray, a pulmonary function study, an arterial blood gas study and a physical examination. Dr. Castle also reviewed an extensive number of medical records, reports, radiographic evidence and diagnostic tests. He addressed the possible effects of Claimant's coal mine employment and smoking history. He opined that both factors could cause pulmonary disease, but only if the Claimant had been a susceptible host. He opined that Claimant was not a susceptible host because there were no signs of interstitial pulmonary process, i.e. no rales, crackles or crepitations, nor any radiographic evidence of pneumoconiosis. Although Dr. Castle classified the x-ray he had interpreted as 1/1 and noted changes between older x-rays and the x-ray taken in conjunction with his examination, he explained that "these changes did not appear to be those of CWP". He opined that the changes were consistent with scarring from inflammatory process such as pneumonia. It is his professional opinion that these changes were from severe pneumonia that required mechanical ventilation in 1996. He also explained that his conclusion that Claimant does not have pneumoconiosis is grounded in the lack of physiologic changes consistent with the disease.

Dr. Castle did find some obstructive impairment, but explained that "the development of this moderate degree of airway obstruction is related entirely and solely to his tobacco smoking habit which continues at the present time. These changes have occurred long after his leaving the coal mining industry in 1987 or 1990. He did not have findings indicating a disabling respiratory impairment long after leaving the mining industry". Based on the arterial blood gas studies, Dr. Castle also found evidence of hypoxemia, which he stated was caused solely by

[14] Dr. Fino reviewed medical records including hospitalizations; DOL examinations; medical record review by Dr. Branscomb; D.O.L examinations; medical letter from Dr. Arora; PFTs from DOL, Koenig and Fino; Chest X-Ray Readings from by Doctors Fox, Halaby, Cole, Castle, Hippensteel, Fino, DeMarino, Orr, Arora, E.N. Sargent, Spitz, Wiot, Navani, Branscomb, Wheeler, Scott, Forehand, Barrett; reviews of occupational and smoking histories.

smoking. He concluded that Claimant was totally and permanently disabled from cigarette smoking and coronary artery disease, and opined that the disability was not caused by coal worker's pneumoconiosis.

Both Dr. Fino and Dr. Castle failed to provide a detailed explanation as to why coal mine employment did not affect Claimant's pulmonary functioning. But their reports indicated that they considered the possible effects of both the employment and smoking history, which Dr. Forehand failed to do. The evaluations by Dr. Fino and Dr. Castle were based upon extensive medical record review, whereas Dr. Forehand's evaluation was not. Both Dr. Castle and Dr. Fino supported their respective diagnoses with specific clinical findings and observations, whereas Dr. Forehand did not. Dr. Forehand failed to provide a well reasoned medical opinion. Dr. Fino and Dr. Castle's medical opinions were both well documented and well reasoned. Therefore I find that the medical opinion evidence does not establish pneumoconiosis.

Newly Submitted Evidence and Total Disability and Causation

The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of § 718.204. A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(1). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. Beatty v. Danri Corp., 16 B.L.R. 1-11, 1-15 (1991). A claimant can be considered totally disabled if the irrebuttable presumption of § 718.304 applies to his claim. If, as in this case, the irrebuttable presumption does not apply, a miner shall be considered totally disabled if in absence of contrary probative evidence, the evidence meets one of the § 718.204(b)(2) standards for total disability. The regulation at § 718.204(b)(2) provides that pulmonary function studies, arterial blood gas tests; a cor pulmonale diagnosis; and/or a well-reasoned and well-documented medical opinion concluding total disability may be criteria when determining total disability.

Section 718.204(c) provides that, in the absence of contrary probative evidence, evidence which meets the quality standards of the subsection shall establish a miner's total disability. Under this section, "all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element." Mazgaj v. Valley Camp Coal Co., 9 B.L.R. 1-201, 1-204 (1986). Mere weighing of like/kind evidence is not sufficient. Specifically, it is error to look at all the pulmonary function studies and conclude that the miner is totally disabled, or to look at all the blood gas studies to conclude that the miner is totally disabled. All the evidence of record must be considered in order to determine whether the record contains "contrary probative evidence." If so, this evidence must be assigned appropriate weight in order to determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." Troup v. Reading Anthracite Coal Co., 22 B.L.R. 1-11 (1999) (en banc); Fields v. Island Creek Coal Co., 10 B.L.R. 1-19, 1-21 (1987); Shedlock v. Bethlehem Mines Corp., 9 B.L.R. 1-195, 1-198 (1986).

Under § 718.204(b)(2)(i) total disability may be established with qualifying pulmonary function tests. To be qualifying, the FEV1, as well as the MVV or FVC values, must equal or fall below the applicable table values. Tischler v. Director, OWCP, 6 B.L.R. 1-1086 (1984). The reliability of a study is dependant upon its conformity to the applicable quality standards, Robinette v. Director, OWCP, 9 B.L.R. 1- 154 (1986), which is based in part upon medical opinions of record regarding reliability of a particular study. Casella v. Kaiser Steel Corp., 9 B.L.R. 1-131 (1986). In assessing the reliability of a study, greater weight may be accorded to the opinion of a physician who reviewed the tracings. Street v. Consolidation Coal Co., 7 B.L.R. 1-65 (1984). Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. Estes v. Director, OWCP, 7 B.L.R. 1-414 (1984). If a study is accompanied by three tracings, then I may presume that the study conforms unless the party challenging conformance submits a medical opinion in support thereof. Inman v. Peabody Coal Co., 6 B.L.R. 1-1249 (1984). Also, little or no weight may be accorded to a ventilatory study where the miner exhibited a poor cooperation or comprehension. Houchin v. Old Ben Coal Co., 6 B.L.R. 1-1141 (1984). However, even if the tests fail to meet regulation requirements, in Crapp v. U.S.Steel Corp., 6 B.L.R. 1-476 (1983), the Board held that a non-conforming pulmonary function study may be entitled to probative value where the results are non-qualifying.

In the pulmonary function tests of record, there is a small discrepancy in the height attributed to Claimant. The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. Protopappas v. Director, OWCP, 6 B.L.R. 1- 221 (1983). In analyzing the pulmonary function test results, I shall utilize the average height reported for Claimant, 68.67 inches. A qualifying pulmonary function study yields values that are equal to or less than the applicable table values found in Appendix B Part 718. 20 C.F.R. § 718.204(b)(2)(i) and (ii). A non- qualifying test produces results that exceed the table values. All three physicians reviewed the tracings, confirming the reliability of each pulmonary function study. Dr. Fino did opine that Claimant did not provide good effort, however this study yielded non-qualifying results, and therefore may still be entitled to probative value. All the pulmonary function testing of record produced non-qualifying values. Accordingly, I find per § 178.204(b)(2)(i), Claimant has failed to establish total disability.

Under § 718.204(b)(2)(ii) total disability may be established with qualifying arterial blood gas studies. All blood gas study evidence of record must be weighed. Sturnick v. Consolidation Coal Co., 2 B.L.R. 1-972 (1980). This includes testing conducted before and after exercise. Coen v. Director, OWCP, 7 B.L.R. 1-30 (1984). In order to render a blood gas study unreliable, the party must submit a medical opinion that a condition suffered by the miner or circumstances surrounding the testing affected the results of the study and, therefore, rendered it unreliable. Vivian v. Director, OWCP, 7 B.L.R. 1-360 (1984) (miner suffered from several blood diseases); Cardwell v. Circle B Coal Co., 6 B.L.R. 1-788 (1984) (miner was intoxicated).

All three of the arterial blood gas studies in the record conform to the applicable quality standards. The December 29, 2003 study conducted by Dr. Forehand was the only study that

included values before and after exercise. The testing conducted both before and after exercise yielded qualifying values. However, the other two arterial blood gas studies, both conducted after Dr. Forehand's study, yielded non-qualifying results. The most recent study was conducted eleven and a half months after Dr. Forehand's study. More weight may be accorded to the results of a recent blood gas study over a study that was conducted earlier. Schretroma v. Director, OWCP, 18 B.L.R. 1-17 (1993). Thus, Claimant has not established total disability under § 718.204(b)(2)(i).

There is no medical evidence of cor pulmonale in the record; therefore, I find Claimant failed to establish total disability with medical evidence of cor pulmonale under the provisions of § 718.204(b)(2)(iii).

The final way to establish a totally disabling respiratory or pulmonary impairment under § 718.204(b)(2) is with a reasoned medical opinion. The opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. Id. A claimant must demonstrate that his respiratory or pulmonary condition prevents him from engaging in his "usual" coal mine employment or comparable and gainful employment. 20 C.F.R. § 718.204(b)(2)(iv). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions.

In assessing total disability under § 718.204(b)(2)(iv) the fact-finder is required to compare the exertional requirements of Claimant's usual coal mine employment with a physician's assessment of Claimant's respiratory impairment. Budash v. Bethlehem Mines Corp., 9 B.L.R. 1-48, 1-51 (holding medical report need only describe either severity of impairment or physical effects imposed by claimant's respiratory impairment sufficiently for an administrative law judge to infer that claimant is totally disabled). Once it is demonstrated that the miner is unable to perform his or her usual coal mine work, a prima facie finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform comparable and gainful work pursuant to § 718.204(c)(2). Taylor v. Evans & Gambrel Co., 12 B.L.R. 1-83 (1988).

Dr. Forehand reported that "a significant respiratory impairment is present; insufficient residual oxygen transfer capacity remains to return to last coal mining job. Unable to work. Totally and permanently disabled." Although it is clear from Dr. Forehand's opinion that he believed Claimant incapable of returning to his previous position in the coal mine, it is unclear whether he considered the exertional requirements of Claimant's previous coal mine employment. Dr. Forehand does list that Claimant's last position was as a foreman, a roof bolter and a cutting machine operator, but he does not provide any description of these jobs, unlike the other physicians that provided medical opinions. An equivocal or vague opinion may be given less weight. Griffith v. Director, OWCP, 49 F.3d 184 (6th Cir.1995). Furthermore, a consideration regarding the probative weight of each opinion on the issue of disability is that Dr. Forehand is the only physician definitively finding pneumoconiosis, which is contrary to the finding of this court. Therefore, the opinions of those physicians not finding pneumoconiosis are entitled to greater weight with regards to the etiology of total disability. Trujillo v. Kaiser Steel

Corp., 8 BLR 1-472 (1986). Again, Dr. Forehand reported a smoking history of three packs per day for forty years, but attributed Claimant's respiratory disability solely to coal mine employment without addressing the possible effects smoking would have on Claimant's disability. For the above reasons, I assign Dr. Forehand's opinion diminished weight.

Both Dr. Fino and Dr. Castle concluded that Claimant is not disabled. Also both physicians found that Claimant did not have pneumoconiosis, which is consistent with this Court's finding, entitling their opinions to greater weight. Trujillo v. Kaiser Steel Corp., 8 BLR 1-472 (1986). Dr. Fino and Dr. Castle also provided a description of Claimant's last job, thereby indicating that they were aware of the exertional requirements associated with the position. Dr. Fino and Dr. Castle are both B-readers. Dr. Fino is board certified in internal medicine with a subspecialty in pulmonary disease; Dr. Castle is board-certified in both internal medicine and pulmonary disease. Dr. Forehand's qualifications were not listed, accordingly I grant more weight to the opinions of Dr. Fino and Dr. Castle.

In Dr. Fino's opinion, Claimant does not have any pulmonary or respiratory impairment. He does opine that Claimant is totally and permanently disabled due to coronary artery disease, however non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. Beatty v. Danri Corp., 16 B.L.R. 1-11, 1-15 (1991). Dr. Fino's opinion is supported by his diagnostic testing, namely there were no qualifying results from any testing conducted during his evaluation of the Claimant. For the above reasons I find Dr. Fino's opinion to be well-reasoned, well-documented and due full weight.

Dr. Castle opined that Claimant is very likely permanently and totally disabled due to both coronary artery disease and tobacco smoke induced pulmonary emphysema. He then went on to describe Claimant's airway obstruction as being moderate in nature. Dr. Castle's examination yielded no qualifying results from either the pulmonary function studies or the arterial blood gas studies. Dr. Castle reports that the arterial blood gas studies show only mild hypoxemia. Dr. Castle on one hand states that Claimant's obstructive impairment is moderate and that the diagnostic tests display only mild hypoxemia, and on the other describes Claimant to be totally and permanently disabled, even though there are no qualifying results from his diagnostics tests to support this contention. For the above reasons I find that Dr. Castle's opinion is not well-reasoned and due lesser weight than Dr. Fino's opinion. With respect to the determination of total disability, I have granted Dr. Forehand's opinion little weight, Dr. Castle's opinion greater weight, and Dr. Fino's opinion the most weight. Claimant has not proven total disability by a preponderance of the evidence. Therefore, I find Claimant has not established total disability by the probative medical opinion reports of record under the provisions of § 718.204(b)(2)(iv).

Weighing all the evidence together, I am faced with one qualifying arterial blood gas study, non-qualifying pulmonary function studies, and medical opinions that together do not support the finding of total disability. Claimant has not established total disability by a preponderance of the evidence. Accordingly, I find Claimant has not established total disability under the provisions of § 718.204(b).

Total disability due to Pneumoconiosis

Since I have found that Claimant failed to prove total disability, the issue of whether total disability is due to pneumoconiosis is moot.

Mistake in a Determination of Fact

Even if a "change in conditions" is not established, evidence in the entire file must be considered to determine whether a "mistake in a determination of fact" was made. This is required even where no specific mistake of fact has been alleged Consolidation Coal Co. v. Director, OWCP [Worrell], 27 F.3d 227 (6th Cir. 1994). New evidence is not a prerequisite to modification based upon an alleged mistake in a determination of fact. Nataloni, 17 B.L.R. at 1-84; Kovac v. BCNR Mining Corp., 14 B.L.R. 1-156, 1-158 (1990), aff'd on recon. 16 B.L.R. 1-71, 1-73 (1992). The fact finder is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." O'Keefe v. Aerojet-General Shipyard, Inc., 404 U.S. 254 at 257 (1971). If a mistake in a determination of fact is found, then the Administrative Law Judge must evaluate all of the evidence and determine the outcome of the claim on the merits.

After a careful review of all of the medical evidence, I find that there has been no mistake in determination of fact in any of the prior decisions in this matter. I have reviewed all the evidence of record, including the Department of Labor medical examination conducted in conjunction with Claimant's October 29, 1998, application for benefits. The District Director's decision rested upon negative x-rays, non-qualifying pulmonary function studies and arterial blood gas tests, and a physician opinion that is inconclusive on the issue.[15] The evidence before him did not establish that the claimant has pneumoconiosis or is totally disabled, and the evidence filed on modification is consistent with his conclusion. Accordingly, I find there to be no mistake of fact in his determination.

I also reviewed Judge Vittone's decision and order denying benefits. I can find no mistake of fact within his analysis. Judge Vittone found that Claimant failed to establish any element required for black lung benefits. The medical evidence from the entire record prior to his decision supports this conclusion. Furthermore, the medical evidence introduced between

[15] Dr. Navani interpreted an x-ray as showing a profusion of 0/1. (DX 1 at 39). While not completely negative, a profusion of 0/1 does not indicate the presence of pneumoconiosis. There was some confusion as to whether Dr. Arora's x-ray interpretation was positive or negative for pneumoconiosis because he indicated that there were abnormalities consistent with pneumoconiosis, but then failed to select a level of profusion. (DX 1 at 40). Dr. Arora later clarified by letter that the x-ray was negative for any change due to pneumoconiosis. (DX 1 at 34). Dr. Arora concluded in his medical report that any impairment is due to a mixture of factors, including cigarette abuse and exposure to coal mine dust. He was unable to determine what impact each of these factors had on the impairment. Given Dr. Arora's inconclusive medical opinion, the lack of qualifying diagnostic tests and the negative radiographic evidence, I find no mistake in the determination of fact in the District Director's denial of benefits.

Judge Vittone's decision and the February 1999 Proposed Decision and Order denying benefits does not support a finding of pneumoconiosis or total disability. And new evidence submitted with the instant claim for modification fails to reveal a prior mistake in determination of fact on the ultimate issue of entitlement. Accordingly, I find that no mistake in determination of fact was made pursuant to 20 C.F.R. §725.310.

Request for Modification

In summary, I find that the newly submitted evidence fails to establish a material change in conditions since the prior denial of benefits. In addition, after a careful review of all of the medical evidence in this matter, I find that there has been no mistake in determination of fact in any of the prior decisions in this matter and that there has been no material change in condition.

ORDER

Claimant's request for modification is hereby **denied.**

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LARRY W. PRICE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).